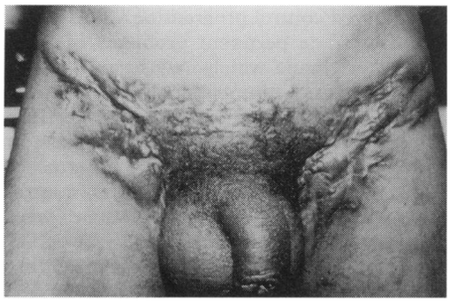

Multiple abscesses, marked inguinal scarring, and genital lymphoedema.

mal limits. The intraderman tuberculin test read 26 mm × 26 mm. Smears stained with Gram's and Ziehl-Neelsen's revealed no organisms. Culture was negative for *M tuberculosis* and *Actinomyces*. Histopathology from the inguinal area was similar to case no 1. The second biopsy from a penile site showed normal epidermis and evidence of dermal fibrosis indicating late lymphoedmatous changes. After 9 months of ATT all signs of active disease had subsided with no significant decline in the genital oedema on follow up.

CASE NO 3

A 28 year old man presented with a lesion on the buttocks for 4 years, diagnosed elsewhere on histopathology as LV. Mantoux test had read 20 mm × 20 mm and chest *x* ray was reported normal. He had been taking ATT for 3 months. Skin lesions had responded but the scrotal swelling persisted. A large atrophic area over both buttocks extending into the medial aspects of the upper thighs was seen. At places erythematous keratotic plaques were present. The inguinal lymph nodes were bilaterally enlarged, discrete, and non-tender. After 6 months of ATT the skin lesions had completely subsided with some reduction in the swelling of scrotum and penis. ATT was stopped and a year later the genitalia resumed the normal appearance.

Discussion

Approximately one sixth of patients with secondary skin tuberculosis present with anogenital lesions without lympho-occlusive complications.[2 3] Occasionally, gigantic overgrowth of the soft tissue of the lower limb following lymphatic obstruction has been seen after repeated attacks of tuberculous lymphangitis.[4]

All our patients had lymphoedema of the genitalia because the superficial horizontal group of inguinal nodes which drain lymph from the prepuce, penile skin, scrotum, vulva, and gluteal region were severely affected. In two the inguinal areas were riddled with scrofuloderma and in the third lupus vulgaris had affected the buttocks. The Mantoux test was strongly positive and *M tuberculosis* was recovered in one with scrofuloderma. Demonstration or recovery of acid fast bacilli is often unsuccessful in lupus vulgaris and scrofuloderma because the organisms are scarce[5]; hence the diagnosis rests on a strong tuberculin reaction, histopathology, and response to ATT. Lymphoedema in the patient with lupus vulgaris regressed well because the impaired lymphatic circulation was restored following ATT, but in scrofuloderma there was more destruction resulting in fibrosis and scars.

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Delivering retested HIV results

In April 1996 the Department of Health arranged follow up of people who had been tested for HIV using the Abbott 1Mx HIV 1/2 third generation plus assay kit after four people with high levels of antibody were found to have been given false negative results. In the UK about 30 000 people had been tested using this kit between September 1995 and March 1996.

In Portsmouth 701 patients had been tested via the genitourinary medicine (GUM) department using the Abbott kit during this period and in accordance with the Department of Health directives we attempted to ensure that all received their results following retesting of stored serum—possible in all except one case where insufficient serum remained.

The news of the possible inaccuracy of HIV tests broke over the 1996 Easter weekend and a telephone line was provided to answer patient inquiries and explain arrangements for retesting and availability of results. The Portsmouth virology laboratory completed all retesting within 10 days. A letter confirming the negative result was sent whenever possible but inevitably some patients attended the department or phoned for results before they had received their letters. Patients were asked to confirm receipt of their result by signing and returning a form in an enclosed stamped addressed envelope. Any patient attending in person or requesting a result by phone was required to provide their date of birth, clinic card, clinic number, or other identification to confirm identity and maintain the usual confidentiality of GUM departments. All 701 patients had attended to receive their original results in person usually at same day testing clinics. We audited the delivery of retested results to patients and how this was achieved (see table).

Method of delivery of retest results

Attended GUM department	48	42 contactable from recorded details
Phoned GUM department	74	59 contactable from recorded details
False details given	2	needed repeat blood sample and retesting
Letters sent	438	298 replies: 279 signed by patient
		5 unsigned
		14 not known at address
No contact requested	62	address recorded in notes
No address recorded	61	
Phone contact	16	10 results given
		1 gone abroad
		3 not known at number
		2 disconnected
Total	701	

A total of 413 out of 701 patients (59%) received confirmed negative results as recommended. The department could have contacted 390 (56%) but a further 62 (9%), although requesting no contact, had provided an address and could possibly have been reached in exceptional circumstances.

Portsmouth has a high student population and the event occurred over a bank holiday when it is possible some patients were away from their usual address. After 2 weeks local newspapers reported that all Portsmouth area retests had been negative so it is likely that some patients, knowing this, did not bother to return their forms as requested. The results for contactability are therefore almost certainly an underestimate.

Although not strictly comparable we contacted the Portsmouth cervical cytology screening unit and found that over a 5 year period 87% of 150 000 eligible women between 20 and 64 years of age responded to a written invitation for a first smear. Of those with an abnormal result < 1% were unable to be contacted.

This was an unusual exercise requiring renewed contact with a large number of patients who had attended the GUM department over the previous 8 months. The results illustrate difficulties which could be encountered in any medium or long term follow up of this predominantly young, mobile population which often attends GUM clinics for a short term anxiety or medical episode.

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Drug interactions of protease inhibitors

The interaction chart for protease inhibitors and lamivudine[1] gives an impressive visual display of a very intricate subject. I would like to pass on a few comments with regard to ritonavir.

Comparing the interactions chart with the latest theoretical kinetic data on ritonavir:

(1) Alcohol is listed as a miscellaneous reaction of clinical significance. There are no data to suggest that alcohol is contraindicated.

(2) Current information predicted largely